County of San Bernardino
Department of Behavioral Health
Investigating and Reporting Death of a Consumer

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Allan Rawland, Director

Purpose

To establish procedures for investigating and reporting the death of a Behavioral Health consumer.

Procedure

Upon receiving notification of the death of a MHP consumer, the following procedure will be followed:

1	The Department of Behavioral Health (DBH) Clinic Supervisor/Contract Agency designee will complete the **Unusual Occurrence/Incident Report** form (QM 053).
2	The Clinic Supervisor or designee will fax the completed Unusual Occurrence/Incident Report within 24 hours to the following: • Appropriate Program Manager • Appropriate Deputy Director • Chief Compliance Officer • Medical Director • DBH Director
3	**In the case of unusual deaths such as homicides, accidents or suicide:** • DBH Clinic Supervisor/Contract Agency designee shall immediately notify the Director's Office • The Chief Compliance Officer will also be required to notify County Risk Management and complete the County **Incident Report Form 15-13866-000**.

3	The Clinic Supervisor or designee will: A. Document information regarding the consumer, such as: 1. Name of Consumer 2. Date of Birth 3. Where case was opened 4. Date case was opened 5. Date consumer was last seen 6. Treating Physician 7. Medications, if any 8. Location of death 9. Cause of death 10. Contact person and phone number B. Audit the consumer's chart for completeness C. Close the chart in SIMON D. Complete the Discharge Summary E. Send the chart to Medical Records.
4	Medical Records will request the consumer's official death certificate. Upon receiving the official death certificate, the Medical Records Supervisor will send the chart to the Medical Director for review.
5	The Medical Director will assign a physician, not related to the case, to perform a review of all records pertaining to the consumer and submit a report of the findings, using the **Quality Assurance Review of Unexpected Deaths** form. This will include, but may not be limited to: • Consumer medical records • Coroner's report • Autopsy report (when available) • Any special incident reports • Appropriate employee interviews (as needed) • Policy report
6	Upon reviewing all the information, the Medical Director will decide if a quality of care issue exists. If there appears to be a quality of care issue, the case will be presented to the Medication Monitoring Committee for review. In selected cases, a Root Cause Analysis Team will also be assembled to review the circumstances of the death and compile a psychological autopsy profile to determine the root cause (if any) of the death and make recommendations for system improvement.
7	The Medical Director or designee will present the findings of the Medication Monitoring Committee to the Quality Management Executive Committee. A copy of the report of the findings will be sent to: • DBH Director • Assistant Director • Chief Compliance Officer.

8	Upon reviewing the information, the Director's Office will determine whether the event should be reported to the Department's Safety Coordinator, County Risk Management and the Chief Administrative Officer.
9	Debriefing for affected staff, consumers and family will be arranged through the **Access Unit. Call (909) 381-2420 during normal business hours, or toll free (888) 743-1478 after hours.**